

Citizens Management Inc.
State of Michigan LTD
P.O. Box 740
Howell, MI 48844-0740

facsimile transmittal

To:

Fax:

From: State of MI Long-Term Disability Plan

Fax: 866-229-4474

Phone: 800-324-9901

Date:

Pages (including cover):

☐ Urgent

☐ For Review

☐ Please Comment

☐ Please Reply

☐ Please Distribute

Per your request an "Attending Provider Statement" form for your patient: _____, is attached. Your patient is seeking Long-Term Disability (LTD) benefits under the State of Michigan Long-Term Disability Plan (LTD Plan). These LTD benefits cannot be approved until Citizens Management Inc. (CMI) conducts a review of your patient's claim.

Please return this form to CMI by either fax (866.229.4474) or mail to:

Citizens Management Inc.
State of Michigan LTD
P.O. Box 740
Howell, MI 48844-0740

Your patient's benefits and claim status may be affected if your office does not provide the required information within twenty (20) calendar days of the date of this notice.

Please contact our Customer Service Department at 1.800.324.9901, Monday through Friday, 8:00 A.M to 5:00 P.M., if you have any questions regarding this correspondence.

Thank you.

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Citizens Management Inc. (CMI) is the Third Party Administrator (TPA) for the State of Michigan Long-Term Disability Plan (LTD Plan). Your patient's benefits and claim status may be affected if your office does not provide the required information within twenty (20) calendar days of the date of this notice.

ATTENDING PROVIDER STATEMENT FOR LONG-TERM DISABILITY (2 PAGES)

| |
|--|
| I understand that falsifying information in order to obtain benefits is grounds for termination of employment and/or benefits and could be subject to civil penalties. |
|--|

Patient Name: First:_____ Last:_____

Birthdate:_____ Job Title:_____

Instructions to Attending Provider (Please print or type).

In order for your patient to receive, or to continue to receive, LTD Benefits, CMI requires the following information be completed in full. Please summarize the period from the date of your last report through the present and return the completed form to the above fax or address.

Current Disabling Diagnosis ICD9: _____

Current Disabling Diagnosis DSM IV (Axis I & II: _____

Surgery/CPT 4: _____ Date: _____

Current Disabling Symptoms: _____

Medical History Impacting This Disability: _____

Claimant name First: _____ Last: _____
Claim number (if known) _____

Current Treatment Plan: (Please include test dates and results, medications with dosage, type and frequency of therapy).

Initial Treatment Date: (for current diagnosis): _____

Most Recent Treatment Date: _____ Next Treatment Date: _____

Hospital Name/City/State: _____ Admit/Discharge Date(s): _____

Consultant Name/Specialty/Phone Number: _____

Exam Date: _____ Released to return to work effective date: _____

*Please complete only if return to work is with restrictions or modifications

May return to work part time: Start date: _____ Hours per day: _____
Through date: _____ Days per week: _____

May return to modified activity: Start Date: _____ Through date: _____

Specify Job Modification(s): _____

*Please complete if patient has not been released to return to work and describe what symptoms support your decision (use a separate page if necessary).

Do you consider the patient **TOTALLY** disabled from **USUAL** occupation? ☐ Yes ☐ No

If yes, please provide dates: From: _____ To: _____

When do you estimate that this patient will be able to return-to-work to **USUAL** occupation?
Date: _____

Do you consider the patient **TOTALLY** disabled from **ANY REASONABLE** occupation? ☐ Yes ☐ No

If yes, please provide dates: From: _____ To: _____

When do you estimate that this patient will be able to return-to-work to **ANY REASONABLE** occupation? Date: _____

PROVIDER INFORMATION AND SIGNATURE MUST BE COMPLETED

Provider Name: _____ Title: _____

Address: _____

Phone Number: _____ Fax Number: _____

Signature: _____ Date of Signature: _____